Chapter 22

Overdose Risks and Prevention Strategies for Pregnant Women in New York City

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Introduction

Like many countries around the world, the United States is in the midst of an overdose crisis. Since 1999, an estimated 700,000 people in the United States have died of an overdose with the majority of those deaths involving opioids (Center for Disease Control and Prevention, 2018). While men account for a greater number of overdose fatalities, the prevalence of overdose is increasing more rapidly among women of reproductive age (Mazure & Fiellin, 2018). Additionally, pregnant and parenting women are more susceptible to unique risk factors compared to their male counterparts, such as limited access to reproductive healthcare, stressful child welfare interventions, and increased stigma within healthcare settings. Although harm reduction services including overdose prevention emphasise compassionate and evidence-based approaches for mitigating drug-related harm, these services services are rarely designed with the various needs of pregnant and parenting women in mind. Gender-responsive harm reduction approaches must take into account factors within the nexus of relevant social systems (i.e. the criminal justice system, women's healthcare, and the child welfare system). Developing harm reduction and overdose prevention strategies for women of reproductive age who may experience pregnancy during their drug use trajectory is a critical area of need that require collaborative efforts with those with lived experience. Using excerpts from interviews with three women who had experienced pregnancy and drug use in New York City, this chapter seeks to highlight

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the importance of inclusive gender-responsive overdose prevention and shared expertise from those with lived experience.

Women Who Use Drugs as Overdose Responders

The widespread availability of naloxone, the medication used to reverse an opioid overdose, is essential in curbing the current opioid overdose crisis. Naloxone is safe and has no potential for abuse, so there is little to no risks in allowing non-medical personnel to administer the medication (Burris, Norland, & Edlin, 2001). Research shows that training and distribution of naloxone to individuals likely to witness an overdose can significantly reduce overdose mortality (Siegler et al., 2017). New York City has made laudable efforts to increase naloxone training and distribution to relevant community-based organisations in order to make this available to those that need it the most – people who use drugs. One participant shared her expertise as an overdose responder:

> I don't panic under pressure. I'm that person that remembers all the steps, you know. I can delegate, you know, 'You, call 911. You, uh, you know, help me with um, you know, CPR' if we have to do it, because we had to at that point. She wasn't breathing. So compressions and breaths and all that. It- it's helpful when you have the ability to recruit people into your situation. And as long as you're giving, you know, concise, clear instructions, people are okay. You know what I mean? If you're, like, freaking out, then it can turn into a shit show pretty quickly.

In 2018, New York City dispensed 95,051 naloxone rescue kits to community members via registered Opioid Overdose Prevention Programs (New York City Department of Health and Mental Hygiene, 2018). A significant number of naloxone rescue kits are dispensed to harm reduction settings. Harm reduction settings are designed to provide low threshold, overdose prevention education to people in the community actively using drugs. Harm reduction programmes often operate in a peer-based, non-judgmental environment. Harm reduction programmes, also known as syringe access programmes, may also provide other drug user health resources such as sterile drug consumption equipment, fentanyl testing strips, condoms, HIV and Hepatitis C testing, or low-threshold access to buprenorphine. All of the women interviewed were connected to harm reduction services in some capacity as participants or employees.

At the time of this publication, drug consumption spaces, also known as supervised injection facilities, were not allowed to operate legally in the United States. As a result, public bathrooms have often been used as convenient locations for people to inject drugs due to the privacy, availability, immediacy, and resources (i.e. water, lighting, and flat surfaces). Thus, it is common for people to use drugs in business locations with private bathroom facilities (Wolfson-Stofko, Bennett, Elliott, & Curtis, 2017). Recognising the overdose risk in many neighbourhoods with high rates of drug use within her community, one participant took it upon herself to educate local business owners on overdose prevention with the use of naloxone.

> I've talked to, like, McDonald's employers, employees, and, um, it's important that they have it, in case they stumble upon somebody in their public bathroom and that, you know, that's clearly, because of the equipment on the floor or whatever, suffering from an overdose. Like, dude, administer. You can't hurt them. You're not gonna make a mistake. Call 911, administer, and have somebody else help you.

The psychological effects of responding to an overdose for women who use drugs – including the benefits and harms of such an experience are an under-researched topic in overdose prevention literature. Participants reported a a feeling of personal responsibility to respond to an overdose within their community. Not only did their fostered connections at harm reduction programmes provide a supportive social environment and access to resources, but their involvement also provided a benefit to share overdose prevention education among their peers and community. Taking on the social role of responding to an overdose has shown to provide valuable, empowering skill sets that include increasing the sense of self-confidence and self-esteem (Wagner et al., 2014). At the same time, certain negative psychological consequences should be considered when examining the impact of being an overdose responder among people who use drugs. Research shows the risks of burnout and trauma among community-based responders is rarely considered in current programmatic support (Shearer, Fleming, Fowler, Boyd, & Mcneil, 2018). Reflecting on experiences as community-based overdose responders, participants shared their thoughts:

> I don't want to lose a loved one. I don't want to lose a best friend. I don't want to lose anybody, even if it is a perfect stranger to know that I could have done something and that I didn't.

> I've always been a part of the user community. And I feel that they have user rights and that they should be supported in their use. They should be supported in any changes they want to make. They should be supported, period. They're human beings.

Barriers to Care for Pregnant Women Who Use Drugs

> My water broke on the bus … I feel like 'I'm pissing myself but I'm not even peeing'. So I went to the doctor and they said, 'You know that you're five months pregnant?' And I was like, 'What? I'm five months pregnant!?'

> Sometimes these things just happen because you have, like, lesser periods or no periods because of your usage. Like, it's hard to tell when you're fucking pregnant to begin with. And morning sickness and dope sickness resembles, you know, so you wind up being many months pregnant when you finally figure it out. You know, that's what happened to me every time.

As the testimonies above illustrate, unexpected pregnancies are common among women who use opioids (Heil et al., 2011). Drug use, especially consistent opioid use,

may delay or stop menstrual cycles. Additionally, early pregnancy symptoms (i.e. vomiting, cramping, and nausea) may be difficult for women who are dependent on opioids to differentiate from withdrawal symptoms (Jones et al., 2008). Furthermore, stigmatisation practices towards people who use drugs are common in healthcare settings (Corrigan, Kuwabara, & O' Shaughnessy, 2009; Mendiola, Galetto, & Fingerhood, 2018). While research is limited on the impacts of stigma in healthcare settings among pregnant women who use drugs, the participants interviewed for this chapter emphasised their experiences of being stigmatised as a leading factor in preventing initial or continued engagement in care.

> They actually treated me like crap when I told them what my problem was. They didn't even want to help me, they didn't want to hear me. All they cared about was, um, and I understand, but all they cared about was the baby, the baby, the baby, the baby, but okay, if the baby is the baby, the baby, the baby, what about hydrating me so that the baby is well, you know?

> Um, it was traumatic. I mean, he was preemie. The nurses were super mean to me at the hospital. You know, every time I would go and, and visit, you know, he was in an incubator. I could barely touch him. They'd look at me and they'd be like, 'Look at him. Look, look at what you did to your son.' So it was fucked up. My mom visited him more in the hospital than I did. I just couldn't bear to take my, you know, to go, because they were just so fucking mean.

> Like, at one point I seriously, like, like, thought about just giving birth at home. Seriously. For fear of them taking my child away at the hospital when, and because of the usage and, like, you know, once you're in the hospital setting, like, you can't just leave. You can't leave with your child. They're gonna take the child because they're gonna test their first urine. And, and it's downhill from there. I have no faith in the you know, child protective services people. They're liars. They, you know, they, they set you up, I, I think, for, for failure. So I really considered just having my baby at home and trying to, you know, Google that shit, like, how to have a home birth. Yeah. That's how, how fearful I was of, of losing yet again another child and not having family there for the support.

In addition to the experience of being stigmatised in healthcare settings, the threat of child welfare involvement or possible criminalisation is also a the reality for women who use drugs. The United States has an extensive history of punitive laws towards women who use drugs during pregnancy laws that are primarily implemented through policing, surveillance, and child removal by the state. Currently, punitive laws far outnumber the existing evidence-based, supportive policies (Thomas Treffers, Berglas, Drabble, & Roberts, 2018). While no law currently exists explicitly criminalising drug use during pregnancy, states have sought prosecution against pregnant people who use drugs in a variety of ways such as declaring prenatal

drug use as a form of child maltreatment, doing drug testing without informed consent, ordering treatment through civil commitment, and mandating child welfare notifications (Thomas Treffers, Berglas, Drabble, & Roberts, 2018). While an analysis of the extent of these punitive policies is beyond the scoop of this article, it is clear that many of these policies violate basic human rights of pregnant women who use drugs. Notably, the overwhelming majority of parents involved in drug-related child welfare investigations are primarily low income and disproportionately women of colour (Stone, 2015). There is no evidence that prosecution or the threat of prosecution deters drug use in pregnancy (Patrick & Schiff, 2017). In fact, research shows that the threat of child welfare involvement instead deters many women from seeking healthcare including prenatal care, supportive social structures, evidenced-based drug treatment, or overdose prevention (Hui, Angelotta, & Fisher, 2017; Nielsen et al., 2019; Stone, 2015). However, opioid use during pregnancy is an easily treatable, temporary, and non-life-threatening condition with no evidence of long-term health consequences for the newborn (Mangat, Schmölzer, & Kraft, 2019). Thus, punitive measures are counterproductive to the health of pregnant women and newborns.

> Because I think they're at higher risk for overdose because they use alone, they use in secrecy. Um, you know, the baby is, is, you know, pretty much taking half of what is going in their system, so they're feeling the effects less, so they, they might increase their amount of usage, which puts them at a higher risk of overdose.

The participant's statement above noted several important overdose risk considerations specifically for drug-using pregnant women – an often overlooked population in overdose prevention education. While there is extensive research in treating opioid use disorder during pregnancy with the use of buprenorphine or methadone – which is also shown to significantly reduce the risk of an opioid overdose – little research exists on responding to an opioid overdose to a pregnant person with the use of naloxone (World Health Organization (WHO), 2014). There is a critical need to expand overdose prevention education for the pregnant population. Women who are pregnant may use alone due to increased stigma by drug-using peers, partners, or family members. Using alone poses a significant risk of dying from an overdose, since it is unlikely that a bystander could intervene with the use of naloxone. To be clear, naloxone should always be administered to anyone experiencing an overdose, regardless of pregnancy (Blandthorn, Bowman, Leung, Bonomo, & Dietze, 2017). While none of the interviewed participants had heard anything about specific considerations when administering naloxone to a pregnant woman – a frequent inquiry at overdose prevention trainings – all participants were correct when assuming pregnancy should never be a reason not to give someone naloxone based on the medication's life-saving purpose.

> But it's better to have someone alive, whether they're pregnant or not, than to have someone, two people dead … as opposed to two people, the mother overdosing and the fetus dying in the process.

Additionally, the postpartum period creates a unique overdose risk for women who have experienced pregnancy. The limited research suggests that some factors

associated with overdose in the postpartum period include poor social support, inadequate healthcare coverage, and recently having an infant experiencing neonatal abstinence syndrome (Nielsen et al., 2019). Similarly, women may self-medicate with continued or increased drug use due to stress and trauma associated with the loss of child custody or child welfare involvement, as one participant described:

> The pregnancies where I was using probably increased after birth only because of the, you know, just the shitty feeling, the depression associated with the fact that I knew that I wouldn't be able to take my baby home or be with my baby.

Conclusion

This brief documentation sheds light on women not only surviving the overdose crisis but also the punitive, stigmatising multi-structural social systems that often affect intersecting with the lives of pregnant women who use drugs. Several areas of further research and programme development were highlighted including the need for gender-responsive overdose prevention provisions, barriers to reproductive health and harm reduction, as well as effective interventions with supportive, trauma-informed approaches. Women who use drugs have proven their expertise in identifying several devastatingly harmful barriers to their own care and critical life-saving interventions. Policymakers, researchers, and practitioners need to ensure that women are no longer adversely impacted by ineffective and harmful policies and practices, which can be accomplished by collectively increasing advocacy efforts to promote the inclusive involvement of women with lived experience of pregnancy and drug use throughout the development, evaluation, and implementation of impacting systems and policies.

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